IAPDC

Independent Advisory Panel on Deaths in Custody
Response to call for evidence on deaths in custody

Introduction

1. The role of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to advise Ministers and officials in England and Wales on how they can meet their human rights obligations to prevent deaths and protect the lives of people detained in state custody.

2. The IAPDC welcomes the opportunity to submit evidence to the United Nations Special Rapporteur on extrajudicial, summary, or arbitrary executions. We have focused our submission on the first request for information around existing practices for data gathering. The IAPDC's submission sets out the key current data, the ways in which this data is collected and published, and some of the key issues the Panel encounters in making use of the data to understand, and direct interventions toward, deaths in custody.

3. There exists a range of practices for gathering, analysing, and reporting deaths in detention data across the different custody settings covered by the IAPDC's remit – prisons, immigration detention, police custody, and detention of patients under the Mental Health Act 1983 (MHA).

4. Data on deaths in detention should be updated and published frequently and be fully disaggregated (included according to protected characteristics and detention type). Services should take steps to understand and sharing findings on cause of death as early as possible. Where possible, deaths data should be published by rate, meaning that information on population sizes and time spent in detention should also be made available.

5. While total numbers are useful, it is often more revealing to understand rates of death according to populations in detention to allow for more consistent comparison across time and settings. Ground-breaking research by the Panel in 2021 examining data on custody deaths between 2016 and 2019 identified the following key findings:

    - Around one in five deaths in detention are self-inflicted.
    - Deaths in all custodial settings are much higher than the background all-cause mortality for the general population of similar age and sex.
    - Most deaths took place in prisons. The highest rate of deaths is in psychiatric hospitals.
    - While there were more deaths of men than women in all settings, when the accompanying rates are considered, the difference in deaths between men and women is narrowed.
    - The proportion of deaths due to natural causes increased in the older age groups, and there were relatively more self-inflicted deaths in the younger age groups.[1]

Data on deaths within prisons

Numbers

6. HM Prison and Probation Service (HMPPS) collects and publishes data on deaths within prison custody. In the 12 months to December 2022 there were 301 deaths, of which 74 were self-inflicted and 187 were from 'natural causes'. There was one homicide and 39 deaths recorded as 'Other' (see paragraph 12).[2]

7. This data is disaggregated by categories including gender, age, prisoner category (e.g. remand status), establishment (e.g. security classification, male/female estate), nationality, time in custody, sentence length and type, offence, and method of self-inflicted death, among others. Data on ethnicity is currently published for self-inflicted

deaths only, though the IAPDC understands there are plans to make this information available for all deaths going forwards.

8. Importantly, HMPPS also publishes rates of deaths per 1,000 prisoners. In the 12 months to December 2022 this rate was 3.7 per 1,000 prisoners.

9. The numbers of deaths remain high, with over 100 more deaths in 2022 than ten years prior. While the number of self-inflicted deaths has decreased since a high of 111 in 2016, this still significantly higher than ten years prior. Deaths from 'natural' causes remain high, similar to the previous high in 2016 (this category can be viewed as somewhat misleading in that it does not capture those deaths which inquests and investigations suggest were caused by physical health issues but likely avoidable). Overdoses and other substance-related deaths are rising. Homicides remain infrequent.

Methodology

10. Deaths data published by HMPPS is viewed as a best practice example in the context of other detention settings in England and Wales.

11. As the MoJ's guide to HMPPS's Safety in Custody Statistics states, "A death in prison custody is defined as 'any death of a person in prison custody arising from an incident in or, on rare occasions, immediately prior to prison custody'."[3]

12. Cause of death information is initially provided on the basis of post-mortem results to classify deaths as 'self-inflicted' or 'natural' at an early stage, with these figures liable to change after the conclusion of further investigations such as inquests. As the MoJ's guide states, "Natural cause deaths include any death of a person as a result of a naturally occurring disease process", while "[s]elf-inflicted deaths are any death of a person who has apparently taken his or her own life irrespective of intent. This not only includes suicides but also accidental deaths as a result of the person's own actions. This classification is used because it is not always known whether a person intended to commit suicide." Further, "'Other' deaths include any death of a person whose death cannot easily be classified as natural causes, self-inflicted or homicide. The category includes accidents and cases where the cause of death is unknown even after all of the investigations have been concluded."

13. Headline data is published via quarterly statistical updates, with a full detailed breakdown on deaths published annually. Data is published which captures deaths which have occurred up to one month before publication. More 'real-time' information is provided to key partners and stakeholders.

Data on deaths in or following police custody

Numbers

14. The Independent Office for Police Conduct (IOPC) collects and publishes data on deaths in or following prison custody. The latest statistics show there were 11 deaths in 2021/22, a decrease of eight from the previous year.[4] There were also 56 apparent suicides following release from police custody, one more than the previous year, and maintaining what has remained a concerning trend.

15. Of police custody deaths, three people died in a police cell, a continuation of a long-term reduction since the 1990s from earlier years.[5] Three died as a result of natural causes and four involved restraint, while six people were identified as having mental health concerns and nine were known to have a link to alcohol and/or drugs.

16. Of the 11 who died in police custody, ten individuals were White and one was Black. Of deaths in or following custody where restraint was used, three were White and one was Black. Of the seven deaths included within the 'Other deaths' category (see paragraph

21) and which involved use of force, five of those who died were White, one was Black, and one was Asian.

Methodology

17. As the IOPC explain in their guidance on their data collection practices, "Under the Police Reform Act 2002, forces in England and Wales have a statutory duty to refer to the IOPC any complaint or incident involving a death which has occurred during or following police contact, and where there is an allegation or indication that the police contact, be it direct or indirect, contributed to the death."[6]

18. Following a referral, "The research team examines the circumstances of all death cases identified to determine whether they meet the criteria for inclusion in the annual death report. Cases are categorised based on the information available from referral documents, investigation reports, post mortems and inquest verdicts. Where information is unknown or unclear from the data available to the research team, for example on cause of death, this will be sought from IOPC colleagues and police forces."

19. In addition, "All cases included in the report are validated with the relevant IPCC/IOPC investigator (where applicable), and police force or appropriate authority. The purpose of this is to provide missing data where possible and flag any cases that are not listed but are considered to meet the criteria for inclusion. These cases will then be checked by the research team."

20. The category of 'deaths in or following police custody', "[i]ncludes deaths that happen while a person is being arrested or taken into detention. It includes deaths of people who have been arrested or have been detained by police under the Mental Health Act 1983. The death may have taken place on police, private or medical premises, in a public place, or in a police or other vehicle." This does not include suicides that occur after a person is released from police custody, deaths where the police are called to assist medical staff to restrain individuals who are at no point under arrest, or "deaths of individuals who have been transferred to the care of another agency and subsequently die while in their care, of injuries or illness not identified or sustained while in police custody."

21. In addition to these reported deaths, the IOPC classify a wider range of deaths within a further category named 'Other deaths following police contact', which comprises 107 further deaths. This category contains a wide variety of deaths related to police contact in a range of different ways, including those who died while evading arrest or who died while police were seeking to do welfare checks related to those individuals. They are collected together on the basis that they are all other deaths, outside of police custody, which the IOPC determined required independent investigation.

22. However, concerns have been raised, including by the IAPDC, that this category includes concerning examples of police contact deaths – cases such as the manslaughter killing of Dalian Atkinson by a police officer, but whose deaths is not recorded as part of custody-related deaths for the fact that he was not arrested.[7] The classification of this category remain opaque, as do what themes and learning are drawn from it.[8]

Data on deaths within Mental Health Act detention

Numbers

23. The Care Quality Commission (CQC) reported that 270 people died during detention under the MHA during the year 2021/22.[9] Of these, 165 were classified as 'natural', 50 as 'unnatural', and 55' as 'undetermined'. 15 deaths involved the use of restraint. 192 of

these deaths were White, while 46 were Black or of another ethnic minority group. However, ethnicity was not recorded for 32 deaths.

24. The IAPDC's research from 2021 found that people detained under the MHA have the highest mortality rate of those in custody, three times higher than the mortality rate in prisons.[10]

Methodology

25. The CQC receive this data directly from providers, which are legally required to notify CQC of any deaths within their care as soon as possible after they take place. However, this data is limited in several key ways.

26. Available data is patchy and reliant on a yearly, rather than rolling, publication of figures that contain a large number of deaths about which little is known. This makes it difficult to understand the full picture of deaths of those detained under the MHA, and therefore how to target interventions to reduce them.

27. The data is only reported once a year in the CQC's annual 'Monitoring the Mental Health Act' report. This means that Government departments, such as the Department of Health and Social Care, are unable to provide to Parliament or the public rolling, updated figures across the year to give an accurate picture of deaths, and instead rely on one set of figures released once per year.

28. In addition, there are a large number of deaths that are classified as being of 'Undetermined' cause – indeed for the last reporting year 20% of deaths were not known. This is likely because, unlike HMPPS, which largely relies on the outcome of post-mortems, we understand that the CQC largely relies on the findings of inquests, which can often take several years to report. While mental health providers are required to notify CQC of all deaths in their facilities, it appears that the CQC are often notified of deaths without key information, such as cause of death, relying on the CQC to follow up to identify cause of death many months later at the conclusion of an inquest – something which they may not always be successful in doing.

29. There are also issues around the disaggregation of deaths. A large number of these deaths are not recorded by ethnicity – for example, the Panel's 2021 analysis identified that half of the women who died in detention in 2019 did not have their ethnicity recorded.[11] This makes it extremely difficult to identify to what extent individuals may be dying in disproportionate numbers or at a disproportionate rate and how interventions should be subsequently targeted.

30. The available data does not disaggregate for vital categories such as service or ward type to enable us to know in which parts of the mental health treatment estate the largest numbers or rates of deaths are taking place. The data is also likely to miss entirely individuals who die only shortly after leaving MHA detention to be treated in a general hospital, as well as children who die while detained on a *de facto* basis, outside the legal framework of the MHA.

31. Information on length of stay or population size in detention is also not robustly available. This makes it difficult to calculate rates of deaths within MHA settings, something that is vital to understanding risk and safety within these settings.

Data on deaths within immigration detention

Numbers

32. There was one death in 2021, which was self-inflicted. Numbers of deaths within the immigration estate have remained very low in recent years.[12]

33. Data published by the Home Office includes the individuals' sex, ages, nationality, causes of death (natural, self-inflicted, homicide, or 'other'), place of incident, and place of death.

Methodology

34. This data includes people who died while detained under immigration powers in an immigration removal centre (IRC), short-term holding facility (STHF), pre-departure accommodation (PDA) or under escort, or where they left detention as a result of an incident occurring within detention. Cause of death is initially based on the "best assessment of the Home Office", until further information becomes available, such as following the conclusion of an inquest (which may lead to revisions to the published data over time). Where it cannot be easily identified, it is classified as 'Other'.

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[1] IAPDC, 'Statistical analysis of recorded deaths in custody between 2016 and 2019', November 2021, available here.
[2] Ministry of Justice and HMPPS, 'Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2022', 26 January 2023, available here.
[3] MoJ, 'Guide to Safety in Custody Statistics', January 2023, available here.
[4] IOPC, 'IOPC publishes figures on deaths during or following police contact for 2021/22', 28 September 2022, available here.
[5] In 2020/21, three people died in a police cell, in 2019/20 one person died in a police cell, in 2018/19 there were no such deaths, and in 2017/18 there were three such deaths.
[6] IOPC, 'Deaths during or following police contact annual report guidance', January 2018, available here.
[7] Guardian, 'Police formally apologise over Dalian Atkinson death after officer's conviction', 26 December 2021, available here.
[8] IAPDC, 'Preventing deaths at point of arrest, during and after police custody: a review of police practice submitted to the Independent Advisory Panel on Deaths in Custody by Police and Crime Commissioners and associated bodies', December 2022, available here.
[9] CQC, 'Monitoring the Mental Health Act in 2021/22', 1 December 2022, available here.
[10] IAPDC, 'Statistical analysis of recorded deaths in custody between 2016 and 2019', November 2021, available here.
[11] IAPDC, 'Statistical analysis of recorded deaths in custody between 2016 and 2019', November 2021, available here.
[12] For details of this data and its methodology for 2021, please see here.